

5053

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Bel Alton.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PHYSICIANS MEMORIAL</b>				d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>BARGDILL</b>				4. DATE OF DEATH Month Day Year <b>MAY 13 1956</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>US-W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 10, 1956</b>	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>La Plata, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wilburn M. BARGDILL</b>				14. MOTHER'S MAIDEN NAME <b>Rose Elizabeth McCarthy.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>W. M. BARGDILL, Bel ALTON, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory collapse</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity. (infant about 24 wks gestation)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>10 May</b> , 19 <b>56</b> , to <b>13 May</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>13 May</b> , 19 <b>56</b> , and that death occurred at <b>7:15 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. Wooddy</b> M.D. <b>La Plata, Maryland</b>				DATE SIGNED <b>13 May 56</b>			
PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/13/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Ignatius</b>		22d. LOCATION (City, town, or county) (State) <b>BEL ALTON, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. M. BARGDILL, Bel ALTON, MD</b>				24a. REC'D BY REGISTRAR DATE <b>5/14/56</b>		24b. REGISTRAR'S SIGNATURE <b>Julia H. Pusey</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2066394XVI



5054

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physician Memorial Hosp</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>JOSEPH</u> First <u>LORENZO</u> Middle <u>CARTER</u> Last				4. DATE OF DEATH <u>MAY</u> Month <u>5</u> Day <u>19</u> Year <u>56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 15 1905</u>		9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>				13. FATHER'S NAME <u>Thomas Carter</u>			
14. MOTHER'S MAIDEN NAME <u>Alberta Rose Floyd</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>214-18-843</u>				17. INFORMANT <u>Alberta Carter</u> Address <u>La Plata Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Extreme hypertension</u> DUE TO (c) <u>Unknown</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>5-4</u> , 19 <u>56</u> , to <u>5-5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-4</u> , 19 <u>56</u> , and that death occurred at <u>4:15</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>For Johnson</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>For Johnson</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>5-8-56</u>				22c. NAME OF CEMETERY OR CREMATORY <u>St Ignace Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Bel Air Md</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u> ADDRESS <u>Waldorf Md</u>			
24a. REC'D BY REGISTRAR <u>MAY 10 1956</u>				24b. REGISTRAR'S SIGNATURE <u>Mrs. L. Hall Pryor</u>			

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05051**  
**5055 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Charles</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lablata</u> c. LENGTH OF STAY IN TB <u>7 wks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lablata</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Kenny William Casteel</u> First Middle Last <b>4. DATE OF DEATH</b> Month <u>5</u> Day <u>18</u> Year <u>1956</u>				<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>3-30-56</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>0</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>1</u> Days <u>18</u> <b>IF UNDER 24 HRS.</b> Hours <u>1</u> Min. <u>18</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Infant</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____ <b>11. BIRTHPLACE</b> (State or foreign country) <u>md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> _____				<b>13. FATHER'S NAME</b> <u>Kenny Casteel</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Eva Jean Kaiser</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____ <b>16. SOCIAL SECURITY NO.</b> _____ <b>17. INFORMANT</b> <u>" "</u> Address <u>" Lablata Md</u>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a. m. _____ p. m. _____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>F. J. EDELLEN</u> M.D. <b>EXAMINER'S NAME (Type)</b> <u>F. J. EDELLEN M.D.</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>5/19/56</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> _____				<b>22d. LOCATION (City, town, or county)</b> <u>St. Paul Va.</u> (State) _____			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Kenny Casteel (father)</u> ADDRESS <u>Lablata, md</u>				<b>24a. REC'D BY REGISTRAR</b> DATE <u>5/18/56</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Julius H. Boney</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2066-213433

RECEIVED

MAY 21 1956

BUREAU V. S.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. RACE: [illegible]  
5. DATE OF BIRTH: [illegible]  
6. PLACE OF BIRTH: [illegible]  
7. DATE OF DEATH: [illegible]  
8. PLACE OF DEATH: [illegible]  
9. CAUSE OF DEATH: [illegible]  
10. MANNER OF DEATH: [illegible]  
11. SIGNATURE OF MEDICAL EXAMINER: [illegible]  
12. SIGNATURE OF REGISTRAR: [illegible]  
13. SIGNATURE OF CLERK: [illegible]

5056

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05052

Reg. Dist. No.

103

1. PLACE OF DEATH a. COUNTY <b>Waldorf, Charles Co.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>	c. LENGTH OF STAY IN TB <b>Life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>none</b>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Joan Yvett Duckett</b>		4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-22-1956</b>
9. AGE (In years last birthday) <b>3 Mo. 0 yrs.</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>Robert Duckett</b>	
14. MOTHER'S MAIDEN NAME <b>Hazel Bernardine Marshall</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Hazel Duckett, Waldorf, Md. (Mother)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffocation (Accidental)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>2 Hours</b>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Baby found dead in crib, on stomach with head in pillow</b>	
20c. TIME OF INJURY Month, Day, Year <b>6</b> Hour <b>o. m.</b> <b>5-3-</b> <b>1956</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Waldorf Charles Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>William J. Kurz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William J. Kurz, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 4 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Waldorf, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Stonett Funeral Home</b>		24a. REC'D BY REGISTRAR <b>MAY 1 1956</b>	
ADDRESS <b>Waldorf, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>M. L. Monroes</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4000340405

RECEIVED

MAY 7 1956

BUREAU V. S.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]

## CERTIFICATE OF DEATH

Reg. Dist. No.

100

5057

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If infirmary: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Chas</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT Victoria</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physician's Men Hosp</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>VIRGIE</u> First <u>DXSON</u> Middle Last		4. DATE OF DEATH Month <u>5</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 6 1896</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horse work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Dyson</u>		14. MOTHER'S MAIDEN NAME <u>Frances Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Ethel Key</u> Address <u>MT Victoria MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c-)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X Uremia</u> DUE TO (b) <u>Renal arteriosclerosis</u> DUE TO (c) <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X Cerebral infarct 3 years ago, diabetes, gangrene rt. foot</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>5 yrs.</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I for Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 19 1955</u> to <u>23 May 1956</u> , that I last saw the deceased alive on <u>22 May 1956</u> , and that death occurred at <u>5:38 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>LA PLATA, MD</u> DATE SIGNED <u>5-23-56</u> ACTUAL SIGNATURE <u>F. M. Johnson</u> M.D. PHYSICIAN'S NAME (Type) <u>F. M. JOHNSON M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-26-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Shilo</u>		22d. LOCATION (City, town, or county) (State) <u>Waynes, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Horst's Funeral Home</u> ADDRESS <u>Waldorf MD</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 29 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. F. M. Johnson</u>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. This certificate may be released by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 13

MAY 29 1956

RECEIVED

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05054

5058

## CERTIFICATE OF DEATH

Reg. Dist. No. 101

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Rison</i>		<i>70 yrs</i>		TOWN <i>Rison</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <i>James</i>		(Middle)		(Last) <i>Ennis</i>		(Month) <i>May</i> (Day) <i>30</i> (Year) <i>1956</i>	
<b>5. SEX</b> <i>Male</i>	<b>6. COLOR OR RACE</b> <i>Colored</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>Married</i>	<b>8. DATE OF BIRTH</b> <i>Aug 4, 1881</i>		<b>9. AGE last birthday</b> <i>75</i> yrs.	<b>10. IF UNDER 1 YEAR</b> (Month) <i>5</i> (Day) <i>30</i> (Year) <i>1956</i>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>U.S. Steel Products Co.</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Virginia</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.</i>	
<b>13. FATHER'S NAME</b> <i>Not Known</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Not Known</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>No</i>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Mrs. J. S. Ennis, Rison, Md.</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>1443X</b> IMMEDIATE CAUSE (A) <i>Hypertension Heart Disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>21 yrs.</i>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <i>Hemiplegia</i>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <i>May 28, 1956</i> to <i>May 28, 1956</i> , that I last saw the deceased alive on <i>May 28, 1956</i> , and that death occurred at <i>Midnight</i> from the causes and on the date stated above.							
<b>SIGNATURE</b> <i>Frank H. Quisenberry</i> M.D.		<b>ADDRESS</b> (Street, city, town, state) <i>Indian Head, Md.</i>		<b>DATE SIGNED</b> <i>5-31-56</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Buried</i>	<b>DATE THEREOF</b> <i>6-3-56</i>	<b>NAME OF CEMETERY OR CREMATORY</b> <i>Alexander St. E. Church</i>		<b>LOCATION (City, town, or county)</b> <i>Chickens</i>		<b>(State)</b> <i>Md.</i>	
<b>24. REC'D BY REGISTRAR</b> <i>June 2, 1956</i>	<b>REGISTRAR'S SIGNATURE</b> <i>Mary Southland</i>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Johnson and Jenkins</i>		<b>ADDRESS</b> <i>1702-12th St. N.W.</i>			

128

BUREAU V. S.

9 JUN 1956

RECEIVED

Nov. 2, 1928 Deep. 100 fathoms.

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

# 5059 CERTIFICATE OF DEATH

05055

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <i>Charles</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Charles</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Newburg</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Newburg</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year)	
<i>J. EARL HILL</i>		<i>May 19 1956</i>	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b>	<b>8. DATE OF BIRTH</b>
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>Jan 16 1890</i>
<b>9. AGE last birthday</b>	<b>10. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE (State or foreign country)</b>	
<i>66</i> yrs.	<i>Former</i>	<i>St Marys Md.</i>	
<b>12. CITIZEN OF WHAT COUNTRY?</b>		<i>USA</i>	
<b>13. FATHER'S NAME</b>		<b>14. MOTHER'S MAIDEN NAME</b>	
<i>Perry Hill</i>		<i>Catherine P.</i>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>		<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT &amp; ADDRESS</b>
			<i>Gertrude Mattingly Laplata</i>
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>18. MEDICAL CERTIFICATION</b>	
<b>331X IMMEDIATE CAUSE (A)</b>		<i>Cerebral hemorrhage</i>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>		<i>Hypertension</i>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>		<i>Arteriosclerosis</i>	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>		<i>Previous Cerebral Thrombosis</i>	
<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b>	<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
		<i>3 hrs.</i>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>	<b>21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>	<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>	
<input type="checkbox"/>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>	<b>21e. INJURY OCCURRED White at work Not while at work</b>	<b>21f. HOW DID INJURY OCCUR?</b>	
	<input type="checkbox"/> <input type="checkbox"/>		
<b>22. I hereby certify that I attended the deceased from <i>Aug 1954</i> to <i>May 19 1956</i>, that I last saw the deceased alive on <i>Apr 15 1956</i>, and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above.</b>			
<b>SIGNATURE</b>		<b>DATE SIGNED</b>	
<i>Frederick M. Johnson</i>		<i>2A PLATA, Md. 19 May 56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>	<b>DATE THEREOF</b>	<b>NAME OF CEMETERY OR CREMATORY</b>	<b>LOCATION (City, town, or county) (State)</b>
<i>Burial</i>	<i>5/22/56</i>	<i>St Ignatious</i>	<i>Bel Air Md</i>
<b>24. REC'D BY REGISTRAR</b>	<b>REGISTRAR'S SIGNATURE</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>	<b>ADDRESS</b>
<i>5/22/56</i>	<i>Julia H. Pacey</i>	<i>Richard Lee Laplata</i>	

W. H. H. H.

11/20

BUREAU V. 5

MAY 24 1956

RECEIVED

05056

Reg. Dist. No. 100

5060

106

<b>1. PLACE OF DEATH</b> COUNTY <u>Charles</u> <b>MARYLAND</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Indian Head Md</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b> STATE <u>Maryland</u> COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>2-Cypress Potomac Heights</u> TOWN <u>Indian Head Md.</u> STREET ADDRESS (If rural give location) <u>2-Cypress -Potomac Heights</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) (Type or Print) <u>PAUL ALFRED LINKOUS</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>5-28-56</u> 19__			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>SINGLE</u>	<b>8. DATE OF BIRTH</b> <u>OCT. 11 1909</u>		<b>9. AGE last birthday</b> yrs. <u>46</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>powder factory</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>US GOV.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>VA.</u>			
<b>13. FATHER'S NAME</b> <u>Homer G. Linkous</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Cora B. Price</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>213 03 0895</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Cora B. Linkous Indian Head, Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> <u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Cronic Coronary Heart Disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterio-Sclerosis General</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Innedeiate</u> <u>Indefinite</u> <u>Indefinite</u>			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>3-10-56</u> ....., 19....., to <u>5-28-56</u> ....., 19....., that I last saw the deceased alive on <u>5-28-56</u> ....., 19....., and that death occurred at <u>12:45PM</u> , from the causes and on the date stated above. <b>SIGNATURE</b> <u>James E. Andrews MD.</u> <b>ADDRESS</b> (Street, city, town, state) <u>Indian Head Md</u> <b>DATE SIGNED</b> <u>5-29-56</u>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>June 1 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Western Cemetery</u>			
<b>24. REC'D BY REGISTRAR</b> <u>WIN 4 1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mrs. Oley Price</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Huntt Funeral Home</u>			
<b>LOCATION (City, town, or county)</b> <u>Blacksburg Va.</u>		<b>ADDRESS</b> <u>Waldorf, Md.</u>					

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

1. NAME OF DECEASED

JOHN J. BROWN

2. SEX

MALE

3. AGE

45

4. DATE OF DEATH

JUNE 11, 1956

5. TIME OF DEATH

10:30 AM

6. PLACE OF DEATH

HOME

7. CAUSE OF DEATH

HEART DISEASE

8. MEDICAL HISTORY

NO

9. SIGNATURE OF PHYSICIAN

J. J. BROWN

10. SIGNATURE OF REGISTRAR

J. J. BROWN

11. SIGNATURE OF WITNESSES

J. J. BROWN

12. SIGNATURE OF DECEASED

J. J. BROWN

13. SIGNATURE OF DECEASED

J. J. BROWN

14. SIGNATURE OF DECEASED

J. J. BROWN

15. SIGNATURE OF DECEASED

J. J. BROWN

16. SIGNATURE OF DECEASED

J. J. BROWN

17. SIGNATURE OF DECEASED

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18. SIGNATURE OF DECEASED

J. J. BROWN

19. SIGNATURE OF DECEASED

J. J. BROWN

20. SIGNATURE OF DECEASED

J. J. BROWN

21. SIGNATURE OF DECEASED

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22. SIGNATURE OF DECEASED

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24. SIGNATURE OF DECEASED

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25. SIGNATURE OF DECEASED

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30. SIGNATURE OF DECEASED

J. J. BROWN

31. SIGNATURE OF DECEASED

J. J. BROWN

32. SIGNATURE OF DECEASED

J. J. BROWN

33. SIGNATURE OF DECEASED

J. J. BROWN

34. SIGNATURE OF DECEASED

J. J. BROWN

35. SIGNATURE OF DECEASED

J. J. BROWN

36. SIGNATURE OF DECEASED

J. J. BROWN

BUREAU V. 5

JUN 4 1956

RECEIVED

The City Bank

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5061

CERTIFICATE OF DEATH

05057

Reg. Dist. No.

105

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>			
				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>MICHAEL</b> Middle <b>FLOYD</b> Last <b>MC GUIGAN</b>				4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1956</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 1908</b>		9. AGE (In years last birthday) <b>47</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Applesauce</b>		11. BIRTHPLACE (State or foreign country) <b>Charles Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Joseph Mc Guigan</b>				14. MOTHER'S MAIDEN NAME <b>Susan Adams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>577-18-1948</b>		17. INFORMANT <b>Geneva Mc Guigan</b>		Address <b>Waldorf, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Apoplexy</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma, Pancreas</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1952</b> to <b>May 10, 1956</b> , that I last saw the deceased alive on <b>May 10, 1956</b> , and that death occurred at <b>10 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George S. Weber</b>				ADDRESS (Street, city or town, state) <b>Waldorf Md</b>			
PHYSICIAN'S NAME (Type) <b>George S. Weber</b>				DATE SIGNED <b>5/11/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 11 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Waldorf, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hunt Funeral Home</b>				ADDRESS <b>Waldorf Md</b>		24a. REC'D BY REGISTRAR DATE <b>5/14/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>M. L. Monroe</b>			

1950

— 1 —

**BUREAU V. S.**

MAY 14 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5062 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 176

05058100

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Lomphinsville</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charles</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lomphinsville md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	

<b>3. NAME OF DECEASED</b> (Type or print) <u>Miriam</u> <u>MOORE</u>		<b>4. DATE OF DEATH</b> Month <u>5</u> Day <u>26</u> Year <u>1956</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>July 19, 1901</u>
<b>9. AGE</b> (In years last birthday) <u>54</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>10</u> Days <u>7</u>	

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Lomphinsville</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Lomphinsville Texas</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>md</u>	
<b>13. FATHER'S NAME</b> <u>Edgar A. Ingram</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Draper</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	
<b>17. INFORMANT</b> <u>Lewis Moore Jr.</u>		<b>Address</b> <u>Same Item #2</u>	

<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Coronary Occ</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5-26-56</u>
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<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
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<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	<b>20f. (City or town)</b> <u>Laurel Ches Md</u> (County) (State)

**21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined cause ☐.**

<b>ACTUAL SIGNATURE</b> <u>E. J. EDELEN</u>	<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>	<b>DATE SIGNED</b> <u>5-26-56</u>
<b>EXAMINER'S NAME (Type)</b> <u>E. J. EDELEN</u>	<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>	<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>

<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>5/29/1956</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn</u>	<b>22d. LOCATION (City, town, or county)</b> <u>Rockville</u> (State) <u>Maryland</u>
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<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey-Bethesda, Maryland</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE 5-28-56</u>	<b>24b. REGISTRAR'S SIGNATURE</b> <u>Bennett M. Thompson</u>
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<b>25. A15ME(5)</b> <u>SM 9/55</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Julia T. Parry</u>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2580 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

3561 9 NNC

RECEIVED

1117300

10-11-68  
10-11-68

5063

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived? If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ladysburg</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pischo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Pres Memorial Hosp</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <i>William B. Rhodes</i>		4. DATE OF DEATH Month Day Year <i>May 18 1956</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 24 1885</i>
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sheet Metal</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>W. Rhodes</i>		14. MOTHER'S MAIDEN NAME <i>Marian Perkins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <i>220-268422</i>	
17. INFORMANT <i>Dorothy Wood Rogers</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>422.2</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Enterocolitis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 1955</i> to <i>5/17 56</i> , that I last saw the deceased alive on <i>May 17 1956</i> , and that death occurred at <i>1304</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Frank A. Susan</i> M.D.		<i>Indian Head, Del</i>	
PHYSICIAN'S NAME (Type) <i>Frank A. Susan M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/21/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Charles</i>	22d. LOCATION (City, town, or county) (State) <i>Summit Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home</i>		ADDRESS <i>Washington</i>	
24a. REC'D BY REGISTRAR <i>MAY 22 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Mrs Julia Posy</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

MAY 22 1956

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05060 100

Reg. Dist. No.

280

5064

1. PLACE OF DEATH o. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hughesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charlie Searight</b>		4. DATE OF DEATH Month Day Year <b>May 2 19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1937</b>
9. AGE (In years last birthday) <b>18</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>28</b>	IF UNDER 24 HRS. Hours <b>28</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Jumper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Delivery Truck</b>	
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Zollie Searight</b>		14. MOTHER'S MAIDEN NAME <b>Lurine Armstrong</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mrs. Lurine Searight, Leonardtown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra Cranial Hemorrhage</b> 823X DUE TO (b) <b>Fractured Skull (Base)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Fractured Jaw and left Femur Neck</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile left roadway. Passenger thrown 25 Ft. away</b>	
20c. TIME OF INJURY Month, Day, Year <b>12:50</b> a. m. <b>5</b> 2:56 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 5</b>	20f. (City or town) (County) (State) <b>Hughesville Charles Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>William J. Kurz</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William J. Kurz, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 5, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sandy Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Sandy Ridge, Alabama</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles J. Mattingly, Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>5/3/56</b>	
		24b. REGISTRAR'S SIGNATURE <b>Glen A. Hanes</b> <b>Mrs. F. H. Hanes</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MAY 7 1956

BUREAU V. 3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [REDACTED]  
AGE: [REDACTED]  
SEX: [REDACTED]  
RACE: [REDACTED]  
DATE OF DEATH: [REDACTED]  
PLACE OF DEATH: [REDACTED]  
CAUSE OF DEATH: [REDACTED]  
MANNER OF DEATH: [REDACTED]  
SIGNATURE: [REDACTED]  
DATE: [REDACTED]

5065

## CERTIFICATE OF DEATH

Reg. Dist. No.

101

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Welcome</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) <u>Gert Rude S WENK</u>		4. DATE OF DEATH <u>May 3 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1887</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Joseph Young</u>		14. MOTHER'S MAIDEN NAME <u>Ann E Welsh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Etta Scott</u>		Address <u>Welcome MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO (b) <u>Arteriosclerosis. Cardio-vascular disease 7 yrs</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1949</u> to <u>May 1956</u> , that I last saw the deceased alive on <u>3 May 1956</u> , and that death occurred at <u>10:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur O. Woody</u> M.D.		DATE SIGNED <u>La Plata</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOODY</u>		ADDRESS (Street, city or town, state) <u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-6-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT Rest</u>	22d. LOCATION—City, town, or county (State) <u>LA PLATA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hornett Funeral Home</u>		ADDRESS <u>Waldorf MD</u>	24a. REC'D BY REGISTRAR <u>MAY 8 1956</u>
		24b. REGISTRAR'S SIGNATURE <u>Mrs. Mary Autherland</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

MAY 8 1956

RECEIVED